



Child Care and Early Education Service Eligibility Application

STATE OF NEW JERSEY • DEPARTMENT OF HUMAN SERVICES

ADDRESS REPLY TO:

The Child Care Resource and Referral Agency located in the county where you live. A list can be found at:
<http://www.state.nj.us/humanservices/dfd/programs/child/ccrr/>

A Applicant/Co-Applicant Information Please Read Instructions, Print Clearly, Answer All Questions

1. PARENT/APPLICANT NAME _____ **SOCIAL SECURITY NO.** _____ **DATE OF BIRTH** _____
 _____ (Last) _____ (First) _____ (M.I.) _____ (9 Digit Number) _____ (Mo./Dy./Yr.)
The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.
RACE: American Indian or Alaskan Asian Black or African American Native Hawaiian/Pacific Islander White
ETHNICITY: Hispanic/Latino: Yes No **SEX:** Male Female
Relationship of APPLICANT to children: Father Mother Legally Responsible Adult Foster Parent Other: _____

2. PARENT/CO-APPLICANT NAME (If Applicable) _____ **SOCIAL SECURITY NO.** _____ **DATE OF BIRTH** _____
 _____ (Last) _____ (First) _____ (M.I.) _____ (9 Digit Number) _____ (Mo./Dy./Yr.)
The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.
RACE: American Indian or Alaskan Asian Black or African American Native Hawaiian/Pacific Islander White
ETHNICITY: Hispanic/Latino: Yes No **SEX:** Male Female

3. HOME ADDRESS (Number and Street) _____
 City: _____ State: _____ Zip Code: _____
 County: _____ School District: _____

4. HOME TELEPHONE: _____

5. NUMBER OF ADULTS IN FAMILY: _____ **NUMBER OF CHILDREN IN FAMILY:** _____ **TOTAL FAMILY SIZE:** _____
Family size includes parent, spouse, children for whom subsidy is requested, other dependent children, or adults claimed on applicant's or co-applicant's IRS 1040. In cases of kinship, family size includes the child for whom subsidy is requested and all dependents claimed on the grandparent's, aunt's or relative's IRS 1040. For DYFS cases, a child and any of his/her siblings living in the same home and who are in DYFS-paid out of home placement shall be counted to determine the size of the family.

B Family Income Information Attach Original Proof of Income - Most Recent Four Consecutive Weeks
 Information is not required for DYFS-paid caregivers. Payments for DYFS children in out of home placement does not count as income.

| | PARENT/CO-APPLICANT List gross income for current: | | | | PARENT/CO-APPLICANT List gross income for current: | | | |
|---|---|---------|-------|------|---|---------|-------|------|
| | WEEK | 2 WEEKS | MONTH | YEAR | WEEK | 2 WEEKS | MONTH | YEAR |
| 1. Wages and Salary (gross): | | | | | | | | |
| 2. Pensions, Retirement: | | | | | | | | |
| 3. Supplemental/Social Security Benefits: | | | | | | | | |
| 4. Unemployment, Workmen's Compensation: | | | | | | | | |
| 5. TANF Cash Assistance: | | | | | | | | |
| 6. Child Support/Alimony: | | | | | | | | |
| 7. Other: _____ | | | | | | | | |
| 8. TOTAL GROSS INCOME: | | | | | | | | |

C Work/School/Training Information Proof of Current School Registration Must Be Attached

| | PARENT/CO-APPLICANT | PARENT/CO-APPLICANT |
|--|---|---|
| Name of PRIMARY Work/School/Training Site: Complete Address (Street, City, State, & Zip): <i>(If applicable, enter "Self-Employed")</i> | | |
| Telephone Number: () _____ | () _____ | () _____ |
| Check One: Enter Starting Date (Mo/Dy/Yr): | <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training Start Date ____/____/____ | <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training Start Date ____/____/____ |
| Check One and Enter: Number of Hours/Week and Months/Year for Work/School/Training | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time _____ # Hrs/Wk <input type="checkbox"/> Seasonal Employment _____ # Mos/Yr | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time _____ # Hrs/Wk <input type="checkbox"/> Seasonal Employment _____ # Mos/Yr |
| Name of SECONDARY Work/School/Training Site: Complete Address (Street, City, State, & Zip): | | |
| Telephone Number: () _____ | () _____ | () _____ |
| Check One: Enter Starting Date (Mo/Dy/Yr): | <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training Start Date ____/____/____ | <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Training Start Date ____/____/____ |
| Check One and Enter: Number of Hours/Week and Months/Year for Work/School/Training | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time _____ # Hrs/Wk <input type="checkbox"/> Seasonal Employment _____ # Mos/Yr | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time _____ # Hrs/Wk <input type="checkbox"/> Seasonal Employment _____ # Mos/Yr |

D YES NO

All Questions Must Be Answered. Incomplete Applications Will Not Be Accepted. Supporting Documents Must Be Attached For Verification

- 1. Are you currently participating in the Food Stamp Program?
- 2. Are you currently receiving/have you received assistance for child care with a Temporary Assistance for Needy Families (TANF) or Transitional Child Care (TCC) grant through the Work First New Jersey (WFNJ) Program within the last two years? If yes, indicate when benefits do/did expire by entering Month, Day and Year ____/____/____ and TANF case number: _____
- 3. Is your family an active case with the Division of Youth and Family Services (DYFS) and are the children for whom you are requesting subsidy residing with you? If yes, please give the name of the office: _____
- 4. Are you currently receiving a TANF grant? If yes, please indicate the TANF case number: _____
- 5. Do you or a member of your family have a chronic medical problem for which child care is recommended as part of a treatment/rehabilitation plan? If yes, indicate the name of the individual/agency authorizing the treatment plan and telephone number:
Agency Name: _____ Telephone #: () _____
- 6. Are you the head of the household in which you reside?
- 7. Are you currently homeless or at risk of becoming homeless?
- 8. Are the children for whom you are requesting child care assistance in a DYFS foster home, DYFS para-foster home, or DYFS pre-adoptive home. **If you are employed or participating in a school or training program, proof must be attached for DYFS purposes.**
- 9. Do you receive any cash or voucher assistance to specifically pay for housing?
- 10. Are you requesting assistance because the County Welfare Agency/Board of Social Services (CWA/BSS) informed you that you are ineligible for the Temporary Assistance for Needy Families (TANF) or Transitional Child Care (TCC) Program?
- 11. I understand that I am applying to the agency for: **VOUCHER** payment assistance **CONTRACTED** services in a community-based center
- 12. Do all of the children in this family have health insurance benefits? Yes No
If NO, do you wish to receive an application for NJ Family Care? Yes No

E Children Information

Include Each Child Needing Child Care Service and for Whom Assistance Requested. Use Addendum Form to Provide Information for Additional Children.

FULL NAME OF CHILD NO. 1 SOCIAL SECURITY NO. DATE OF BIRTH
 _____ / ____ / ____
 (Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)
The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.
RACE: American Indian or Alaskan Asian Black or African American Native Hawaiian/Pacific Islander White
ETHNICITY: Hispanic/Latino: Yes No **SEX:** Male Female
 Indicate the hour/days/duration for which child care is needed: _____
 Child has a special need: No Yes **If yes, state special need and attach verification:** _____
 Child is a US citizen or a qualified alien? No Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending
DYFS USE: (Enter the NJ Spirit Case No.) _____ Program: _____ Code: _____ Component: _____
 Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. _____ Mo. _____ Enrollment Date: ____/____/____

FULL NAME OF CHILD NO. 2 SOCIAL SECURITY NO. DATE OF BIRTH
 _____ / ____ / ____
 (Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)
The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.
RACE: American Indian or Alaskan Asian Black or African American Native Hawaiian/Pacific Islander White
ETHNICITY: Hispanic/Latino: Yes No **SEX:** Male Female
 Indicate the hour/days/duration for which child care is needed: _____
 Child has a special need: No Yes **If yes, state special need and attach verification:** _____
 Child is a US citizen or a qualified alien? No Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending
DYFS USE: (Enter the NJ Spirit Case No.) _____ Program: _____ Code: _____ Component: _____
 Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. _____ Mo. _____ Enrollment Date: ____/____/____

FULL NAME OF CHILD NO. 3 SOCIAL SECURITY NO. DATE OF BIRTH
 _____ / ____ / ____
 (Last) (First) (M.I.) (9 Digit Number) (Mo./Dy./Yr.)
The following information is needed for statistical purposes. Check one or more of the appropriate boxes to indicate applicant response.
RACE: American Indian or Alaskan Asian Black or African American Native Hawaiian/Pacific Islander White
ETHNICITY: Hispanic/Latino: Yes No **SEX:** Male Female
 Indicate the hour/days/duration for which child care is needed: _____
 Child has a special need: No Yes **If yes, state special need and attach verification:** _____
 Child is a US citizen or a qualified alien? No Yes **If yes, attach verification (copy of Social Security Card and Birth Certificate or, if applicable, Resident Alien Card)**

AGENCY USE: Status (Check One): Denied Approved Waiting List Pending
DYFS USE: (Enter the NJ Spirit Case No.) _____ Program: _____ Code: _____ Component: _____
 Assessed Co-Payment (Enter and Circle One): \$ _____ Wk. _____ Mo. _____ Enrollment Date: ____/____/____

You May Be Required to Provide Additional Proof of Family Size, Income, Citizenship or Residency to Verify Eligibility. Supporting Documentation Required May Include Most Current IRS Form 1040, Utility Bill or Birth Certificate.